THE HAND CENTER
COLORADO

Medical History

Patient Name:_____ Reason for visit:_____

FAMILY HISTORY: Any history of illness/disease in your family? Y / N
If yes, please describe_____
_____
Are your mother and father living? Y / N

MEDICATIONS: List all drugs you are taking including non-prescription, vitamins, & herbals with dosages:

_____
_____

ALLERGIES List all drugs, food, tape, latex, or anesthesia reactions including post-operative nausea:

_____
_____

PERSONAL HISTORY
Smoking (how much):_____

HOSPITALIZATIONS: List all hospitalizations, operations (including plastic surgery), & serious injuries:

YEAR	HOSPITALIZATION – OPERATION – INJURY	DOCTOR

PAST MEDICAL HISTORY: (Have you ever had the following)

Migraines	Y/N	Asthma	Y/N	Ulcer	Y/N
Glaucoma	Y/N	Angina	Y/N	Irritable Bowel	Y/N
Cancer	Y/N	Heart Disease	Y/N	Hepatitis	Y/N
Thyroid Disease	Y/N	Anemia	Y/N	Bladder Infection	Y/N
Nose Bleeds	Y/N	High Blood Pressure	Y/N	Kidney Disease	Y/N
Sinus Disease	Y/N	Bleeding Disorder	Y/N	Arthritis	Y/N
Stoke	Y/N	Diabetes	Y/N	Skin cancer	Y/N
Seizures	Y/N	Lyme Disease	Y/N	HIV+	Y/N
Emotional Disorder	Y/N			Other	

REVIEW OF SYSTEMS: (Do you have any of the following)

Dry Eyes	Y/N	Palpitations	Y/N	**WOMEN ONLY**	
Dizziness	Y/N	Chest Pain	Y/N	Number of Pregnancies _____	
Deafness	Y/N	Shortness of Breath	Y/N	Number of Living Children _____	
Cough	Y/N	Abdominal Pain	Y/N	Did you breastfeed	Y/N
Painful Urination	Y/N	Low Blood Sugar	Y/N	Last Mammogram _____	
Bruise Easily	Y/N	Depression	Y/N	Last Pap Smear _____	
				Breast Lump or Discharge	Y/N

I VERIFY THAT THE ABOVE INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature of Patient or Parent_____

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